STATE OF OHIO
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

1. DESIGNATION OF ATTORNEY-IN-FACT

I, _____,

presently residing at_____, Ohio,

(the "Principal") being of sound mind and not under or subject to duress, fraud or undue influence, intending to create a Durable Power of Attorney for Health Care under Chapter 1337 of the Ohio Revised Code, as amended from time to time, do hereby designate and appoint:

_____ _____ presently residing
(Name) (Relationship)

at_____ Phone_____ as my

attorney-in-fact who shall act as my agent to make health care decisions for me as authorized in this document.

2. GENERAL STATEMENT OF AUTHORITY GRANTED. I hereby grant to my agent full power and authority to make all health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so, at any time during which I do not have the capacity to make informed health care decisions for myself. Such agent shall have the authority to give, to withdraw or to refuse to give informed consent to any medical or nursing procedure, treatment, intervention or other measure used to maintain, diagnose or treat my physical or mental condition. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent by me or, if I have not made my desires known, that are, in the judgment of my agent, in my best interests.

3. ADDITIONAL AUTHORITIES OF AGENT. Where necessary or desirable to implement the health care decisions that my agent is authorized to make pursuant to this document, my agent has the power and authority to do any and all of the following:

(a) If I am in a terminal condition, to give, to withdraw or to refuse to give informed consent to life-sustaining treatment, including the provision of artificially or technologically supplied nutrition or hydration;

(b) If I am in a permanently unconscious state, to give, to withdraw or to refuse to give informed consent to life-sustaining treatment; provided, however, my agent is not authorized to refuse or direct the withdrawal of artificially or technologically supplied nutrition or hydration unless I have specifically authorized such refusal or withdrawal in Paragraph 4;

(c) To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, all of my medical and health care facility records;

(d) To execute on my behalf any releases or other documents that may be required in order to obtain this information;

(e) To consent to the further disclosure of this information if necessary;

(f) To select, employ, and discharge health care personnel, such as physicians, nurses, therapists and other medical professionals, including individuals and services providing home health care, as my agent shall determine to be appropriate;

(g) To select and contract with any medical or health care facility on my behalf, including, but not limited to, hospitals, nursing homes, assisted residence facilities, and the like;

(h) To execute on my behalf any or all of the following:

(1) Documents that are written consents to medical treatment, Do Not Resuscitate orders, or other similar orders;

(2) Documents that are written requests that I be transferred to another facility, written requests to be discharged against medical advice, or other similar requests; and

(3) Any other document necessary or desirable to implement health care decisions that my agent is authorized to make pursuant to this document.

4. WITHDRAWAL OF NUTRITION AND HYDRATION WHEN IN A PERMANENTLY UNCONSCIOUS STATE.

_____ ❑ IF I HAVE MARKED THE FOREGOING BOX AND HAVE PLACED MY INITIALS ON THE LINE ADJACENT TO IT, MY AGENT MAY REFUSE, OR IN THE EVENT TREATMENT HAS ALREADY COMMENCED, WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY SUPPLIED NUTRITION AND HYDRATION IF I AM IN A PERMANENTLY UNCONSCIOUS STATE AND IF MY ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT SUCH NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO ME OR ALLEVIATE MY PAIN.

5. DESIGNATION OF ALTERNATE AGENT. Because I wish that an agent shall be available to exercise the authorities granted hereunder at all times, I further designate each of the following individuals to succeed to such authorities and to serve under this instrument, in the order named, if at any time the agent first named (or any alternate designee) is not readily available or is unwilling or unable to serve or to continue to serve:

First Alternate Agent:_____ _____
(Name) (Relationship)

presently residing at_____ Phone:_____

Second Alternate Agent:_____ _____
(Name) (Relationship)

presently residing at_____ Phone:_____

Each alternate shall have and exercise all of the authority conferred above.

6. **NO EXPIRATION DATE.** This Durable Power of Attorney for Health Care shall not be affected by my disability or by lapse of time. This Durable Power of Attorney for Health Care shall have no expiration date.

7. **SEVERABILITY.** Any invalid or unenforceable power, authority or provision of this instrument shall not affect any other power, authority or provision or the appointment of my agent to make health care decisions.

8. **PRIOR DESIGNATIONS REVOKED.** I hereby revoke any prior Durable Power of Attorney for Health Care executed by me under Chapter 1337 of the Ohio Revised Code.

I understand the purpose and effect of this document and sign my name to this Durable Power of Attorney for Health Care after careful deliberation on _____ at _____, Ohio.
(Date) (City)

_____
Principal

THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE WILL NOT BE VALID UNLESS IT IS EITHER 1) SIGNED BY TWO ELIGIBLE WITNESSES AS DEFINED BELOW WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR 2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

I attest that the principal signed or acknowledged this Durable Power of Attorney for Health Care in my presence, that the principal appears to be of sound mind and not under or subject to duress, fraud, or undue influence. I further attest that I am not the agent designated in this document, I am not the attending physician of the principal, I am not the administrator of a nursing home in which the principal is receiving care, and that I am an adult not related to the principal by blood, marriage or adoption.

Signature:_____ Residence Address:_____

Print Name:_____ _____

Date:_____ _____

Signature:_____ Residence Address:_____

Print Name:_____ _____

Date:_____ _____

OR

ACKNOWLEDGEMENT

State of Ohio County of _____ss:

On this the _____day of _____, 20_____, before me, the undersigned Notary Public, personally appeared_____, known to me or satisfactorily proven to be the person whose name is subscribed to the above Durable Power of Attorney for Health Care as the principal, and acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

My Commission Expires:_____ _____
Notary Public

NOTE: YOU MAY WISH TO GIVE EXECUTED COPIES OF THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE TO THE AGENT NAMED IN THIS DOCUMENT, EACH ALTERNATE AGENT, AND TO YOUR LAWYER, YOUR PERSONAL PHYSICIAN AND MEMBERS OF YOUR FAMILY.

The following notice is included in this printed form as required by Ohio Revised Code Section 1337.17.

NOTICE TO ADULT EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney-in-fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney-in-fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney-in-fact GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney-in-fact to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, even if the attorney-in-fact has general authority to make health care decisions for you under this document, the attorney-in-fact NEVER will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:

(a) You are suffering from an irreversible, incurable and untreatable condition caused by disease, illness, or injury from which (i) there can be no recovery and (ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

(b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if he is not prohibited from doing so under (4) below, the attorney-in-fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). (YOU SHOULD UNDERSTAND THAT COMFORT CARE IS DEFINED IN OHIO LAW TO MEAN ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) WHEN ADMINISTERED TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH, AND ANY OTHER MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE THAT WOULD BE TAKEN TO DIMINSH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH. CONSEQUENTLY, IF YOUR ATTENDING PHYSICIAN WERE TO DETERMINE THAT A PREVIOUSLY DESCRIBED MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN, THEN, SUBJECT TO (4) BELOW, YOUR ATTORNEY-IN-FACT WOULD BE AUTHORIZED TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE.);

(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

(4) REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISIONS OF ARTIFICALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) TO YOU, UNLESS:

(a) YOU ARE IN A TERMINAL CONDITION OR IN A PERMANENTLY UNCONSCIOUS STATE.

(b) YOUR ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED YOU DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN.

(c) IF, BUT ONLY IF, YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE, YOU AUTHORIZE THE ATTORNEY-IN-FACT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU BY DOING BOTH OF THE FOLLOWING IN THIS DOCUMENT:

(i) INCLUDING A STATEMENT IN CAPITAL LETTERS THAT THE ATTORNEY-IN-FACT MAY REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU IF YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE AND IF THE DETERMINATION THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN IS MADE, OR CHECKING OR OTHERWISE MARKING A BOX OR LINE (IF ANY) THAT IS ADJACENT TO A SIMILAR STATEMENT ON THIS DOCUMENT;

(ii) PLACING YOUR INITIALS OR SIGNATURE UNDERNEATH OR ADJACENT TO THE STATEMENT, CHECK, OR OTHER MARK PREVIOUSLY DESCRIBED.

(d) YOUR ATTENDING PHYSICIAN DETERMINES, IN GOOD FAITH, THAT YOU AUTHORIZED THE ATTORNEY-IN-FACT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU IF YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE BY COMPLYING WITH THE REQUIREMENTS OF (4)(c)(i) AND (ii) ABOVE.

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising his authority to make health care decisions for you, the attorney-in-fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney-in-fact by including them in this document or by making them known to him in another manner.

When acting pursuant to this document, the attorney-in-fact GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

Generally, you may designate any competent adult as the attorney-in-fact under this document. However, you CANNOT designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney-in-fact under this document. Additionally, you CANNOT designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney-in-fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your Durable Power of Attorney for Health Care generally will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney-in-fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney-in-fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicates it to your attending physician.

If you execute this document and create a valid Durable Power of Attorney for Health Care with it, it will revoke any prior, valid Durable Power of Attorney for Health Care that you created, unless you indicate otherwise in this document.

This document is not valid as a Durable Power of Attorney for Health Care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney-in-fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

Provided as a public service by the Ohio Hospice and Palliative Care Organization with the cooperation of the Ohio State Medical Association, the Ohio Hospital Association's Foundation for Healthy Communities and the Ohio State Bar Association, the organizations responsible for developing the forms.